TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Aggarwal, Ved V MD

Respondent Name
Texas Mutual

MFDR Tracking Number
M4-17-0821-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
November 28, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Our Physicians are for Pain Management, we are a CLIA (Certified Laboratory Improvement Amendments) and therefore we are not Required to have Authorizations prior to the Blood testing to be done for the services rendered."

Amount in Dispute: $528.13

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Rule 134.600 (p)(12) states preauthorization is required for treatments and services that exceed or are not addressed by the commissioner's adopted treatment guidelines or protocols and are not contained in a treatment plan preauthorized by the insurance carrier. Texas Mutual has no record of preauthorizing a treatment plan involving such testing. No payment is due absent preauthorization."

Response Submitted by: Texas Mutual

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 19, 2016	82306, 82533, 82607, 82670, 83001, 83002, 84270, 84403, 84439, 84443, 84481	$528.13	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.600 sets out the requirements for prospective and concurrent review of

health care.

3. 28 Texas Administrative Code §137.100 sets out treatment guidelines.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 16 – Claim/service lacks information or has submission/billing error(s)
   - 197 – Precertification/authorization/notification absent
   - 225 – The submitted documentation does not support the service being billed. We will re-evaluate this upon receipt of clarifying information
   - 762 – Denied in accordance with 134.600(p)(12) treatment/service in excess of DWC treatment guidelines (ODG) per disability management rules
   - W3 – In accordance with TDI-DWC Rule 134.804, this bill has been identified as a request for reconsideration or appeal
   - 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly

Issues

1. Are the insurance carrier's reasons for denial or reduction of payment supported?
2. Is the requestor entitled to additional reimbursement?

Findings

1. The insurance carrier denied disputed services with claim adjustment reason code 762 – "Denied in accordance with 134.600 (p)(12) treatment/service in excess of DWC treatment guidelines (ODG) per disability management rules." 28 Texas Administrative Code §134.600 (p)(12) states in applicable part,

> Non-emergency health care requiring preauthorization includes:
>
> > Treatments and services that exceed or are not addressed by the commissioner's adopted treatment guidelines or protocols and are not contained in a treatment plan preauthorized by the insurance carrier.

The reported ICD10 diagnosis is Z79.899 – "Other long term (current) drug therapy" and Z79.891 – "Long term (current) use of opiate analgesic."

The Division reviewed the Office of Disability Guidelines, (ODG) "Pain Chapter" and found:

CRITERIA FOR USE OF OPIOIDS

Long-term Users of Opioids (6-months or more)

1) Re-assess

(a) Has the diagnosis changed?

(b) What other medications is the patient taking? Are they effective, producing side effects?

(c) What treatments have been attempted since the use of opioids? Have they been effective? For how long?

(d) Document pain and functional improvement and compare to baseline. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. Information from family members or other caregivers should be considered in determining the patient's response to treatment. Pain should be assessed at each visit, and functioning should be measured at 6-month intervals using a numerical scale or validated instrument.

(e) Document adverse effects: constipation, nausea, vomiting, headache, dyspepsia, pruritus, dizziness, fatigue, dry mouth, sweating, hyperalgesia, sexual dysfunction, and sedation.

(f) Does the patient appear to need a psychological consultation? Issues to examine would include motivation, attitude about pain/work, return-to-work, social life including interpersonal and work-related relationships.

(g) Is there indication for a screening instrument for abuse/addiction? See Substance Abuse Screening.

2) Strategy for maintenance

(a) Do not attempt to lower the dose if it is working

(b) Supplemental doses of break-through medication may be required for incidental pain, end-of dose pain, and pain that occurs with predictable situations. This can be determined by information that the patient provides from a pain diary or evaluation of additional need for supplemental medication.

(c) The standard increase in dose is 25 to 50% for mild pain and 50 to 100% for severe pain (Wisconsin)

3) Visit Frequency

(a) There is no set visit frequency. This should be adjusted to the patient's need for evaluation of adverse effects, pain status, and appropriate use of medication, with recommended duration between visits from 1 to 6 months.

The requestor states in pertinent part, "Our Physicians are for Pain Management…"

Based on the above requestor's position statement, and review of the applicable ODG Guideline finding no indication of "Blood Testing" being recommended in the "Pain" section of the ODG, the carrier's denial is supported.

2. 28 Texas Administrative Code §137.100 (d) states,

> The insurance carrier is not liable for the costs of treatments or services provided in excess of the Division treatment guidelines unless;
>
> (1) The treatment(s) or service(s) were provided in a medical emergency; or
>
> (2) The treatment(s) of service(s) were preauthorized in accordance with §134.600 or §137.300 of this title

The Division finds insufficient information to support the above mentioned requirements were met. Therefore, no additional reimbursement can be recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

		December 15, 2016
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.